Model for a Public Health Training Institute

This model is based on information gathered and views expressed by individuals in Montana over the past 5 months. Sources of information include:

- *A training needs survey completed by approximately 140 people in the State of Montana in November*
- *A follow-up key informant telephone survey with 16 individuals in the state in late January*
- *A meeting of approximately 20 individuals in state and local public health and from the University of Montana in mid-December*
- *Numerous phone conversations and review of written materials by the Institute Ad Hoc Advisory Group from October to present*
- *Review and comment on the model by over 75 people throughout the state at a one day forum held in February*

The model does not represent views held by any single person but rather is a composite of views from hundreds of individuals.

The model has 8 different components to consider—curriculum, administration, training modalities, financing, evaluation, location, eligibility, and phase-in.

Curriculum

- The Institute will be viewed as a career-long learning center comprised of groups of interrelated modules and one-time only clinical/technical course offerings. The Institute will be invested with insuring that new practitioners meet minimum requirements, that existing practitioners receive regular updates in public health practice and that all practitioners are offered opportunities to build skills and networks leading to career advancement.

- Training received through the Institute will be acknowledged in a variety of ways. For those courses where it applies, continuing education credits will be received upon completion. The institute will work with colleges and universities to explore whether credit from successful completion of one or more courses could be applied toward a public health certificate program or an advanced public health degree.

- Recognition of successful completion of training may be turned, in the future and with careful thought, to certification of minimum competency and could be used as a minimum standard for employment and/or advancement (the institute could certify, but the decision about how certification could be used would need to be made by DPHHS, DEQ and/or local health departments).

- Training will be organized by modules such that all public health workers will be encouraged (and, perhaps required) to participate in the basic public health practice module and possibly community assessment with a test-out option. The more specialized modules may be more appealing/appropriate to a smaller percentage of public health practitioners and their affiliates.

- Each module will have stated outcomes. The "success" of the module will be measured according to the expected outcomes.

- The modules can be viewed as a progression where information and skills acquired in one module build upon other modules. However, completion of one module is **not** a prerequisite for entering another module with the exception of the public health practice module. ***(Examples of modules and the type of topics that could be covered in a module are in the Attachment).***

Training Modalities

- The Institute will use a range of training modalities e.g. teleconferencing, web based training as well as more traditional on-site instruction in order to meet the needs of the varied personnel and learning styles. Each module will have a mix of modalities including face-to-face instruction. The content of the module will determine the type of training methods used; a specific module may be offered in more than one modality, recognizing that there are different types of learners.

- Regardless of the training modality and to the extent possible, health departments will allocate training time during the paid work day (at least for those modules deemed basic or required) in order to encourage participation and ensure commitment, professionalism and accountability.

- Over time, the institute will emphasize promoting and improving web-based instruction.

- The combined training modalities will build a public health infrastructure that could potentially be used for other purposes.

- A thorough assessment of distance learning technologies in each region will be done before establishing training modalities for each module.

- All training modalities will have as their goal short interactions reinforced over time rather than extended periods of training. For instance, face-to-face training will be a maximum of one to two days at a time, long enough to justify the inevitable travel but not disrupt service delivery.

- Distance learners will be assisted in using the distance learning technology. At a minimum, they will be matched with the technology available to them and appropriate to their learning style, and taught specific skills on how to learn via distance learning methodologies; for instance, computer based training may need to have computer skills taught first before the content.

- Information will be packaged in a variety of different ways and reinforced at regular intervals. Case studies and local data will be an integral part of instruction.

- Mentoring will be considered an integral part of training.

- Train-the-trainer programs will be evaluated for inclusion.

Administration

- DPHHS will administer the public health training institute in conjunction with an Institute Advisory Board composed of public health personnel and affiliates. The advisory board will be all inclusive, with representatives of institutions of higher learning, county commissioners, board of health members, hospital employees, environmental regulators, tribal health representatives, Indian Health Service, MEHA, MPHA, and other community-based individuals/groups and consumer groups; in addition, it will have representation from each of the regions and a good rural/urban mix. DPHHS/DEQ, with the advice of the board will decide, at a minimum, upon issues of curriculum offerings, phase-in of modules/topics, training sites, eligibility for training, fees, and institute support.

- DPHHS will decide which parts of the institute will be contracted out initially and which parts will remain with the state. An RFP will be issued for those parts that will be put out to contract.

- After the infrastructure is in place and the initial modules have been offered and evaluated, DPHHS should consider transitioning administration of the institute to a non-profit organization.

- DPHHS and the advisory group will be responsible for matching offerings and modules to public health needs

- Schools of public health from other states should have a physical presence in Montana on order to encourage public health professionals to pursue a higher degree in public health.

Financing

- DPHHS will need to show policymakers the value of the institute (financial and other) in the state. This analysis will be used to advocate for the institute and apply for funding. In addition, there should be some analysis of the perceived benefit of training to the individual i.e. what will be the individual gain from his/her investment (both time and money).

- The training institute should coordinate with other public health trainings offered throughout the state, particularly those offering clinical and technical training.

- Basic courses focusing on minimum standards will be available at reduced cost to the individual through the Institute. Courses deemed to enhance individual skills, career opportunities and advancement, etc. will be offered for a reasonable fee based on market price. The fee structure depends upon the type of module and its length. All participants will be expected to bear some cost of the training although DPHHS feels the responsibility to fund the public health practice training module; scholarships and sliding fees will be available on a case-by-case basis.

- The state must identify a dedicated source of revenue e.g. endowment, trust, earmarked tax if the institute is to survive long term. In addition, the state should investigate trainings targeting the private sector and other community partners that could generate other revenue e.g. occupational health and safety to industry; community assessment, communication, leadership to non-traditional public health partners.

- Support for the Institute will come from a combination of state and local health department funds, private sources, grant support and fees as no one source, initially, is sufficient to support its full cost. Local health department's financial contribution could include in-kind contribution of wages.

Evaluation

- Evaluation measures will be built into the model that could provide information on efficiencies gained, increased effectiveness of services, improvement to the public health system as a whole, suitability of training material, etc.

Location of Training

- The public health training institute will not be a place per se but a collection of modules that will be offered in regional sites, and if sufficient "critical mass" or other extenuating circumstances, individual health departments or sites around the

state. Definition of region will need to be explored–6 health planning regions? 15 MACO regions? 20 judicial districts? Modules drawing more people (such as the public health practice module) would be offered in regional sites; modules drawing fewer people may be at more centrally located sites throughout the state.

- While the delivery of training will be decentralized, the content of the training will be overseen and maintained centrally.

- To the extent possible, training modules will be coordinated with, and delivered at, other organizational and professional group meetings e.g. MPHA, regional meetings.

- When considering locations for training, the concept of study groups/learning teams and mentors should be taken into consideration.

Eligibility for Training

- DPHHS and the advisory board, in consultation with local health departments, will set parameters for who will be eligible for training. Generally, anyone wanting to take a course should be eligible given space constraints. Initially, priority will be given to staff in public health agencies and their affiliates.

Phase-in Considerations

- The basic public health practice module will be the first module offered to people from each region in the state including all staff working in public health and public health affiliates e.g. board of health members, county commissioners. This module will be evaluated over the course of the year at the same time that other specialty modules are being developed.

- Support from local public health leadership will reinforce the importance and value of staff training in improving the public health system as a whole.

- To the extent possible, the following mixes should occur during phase-in: experienced people with inexperienced, people of different regions, personal health workers with environmental health, and rural staff with urban. The mixtures should then be evaluated for efficacy.

- The Institute will explore whether to offer other, off-the-shelf training topics during the phase-in period. These could include grant writing, marketing, meeting facilitation, and computer training. The issue here would be how to fold the off-the-shelf training into a more comprehensive module.

Appendix

Examples of Possible Modules and Topics for the Montana Public Health Training Institute

Modules	*Topics*
Public Health Practice:	Epidemiology/biostatistics Public health history Public health law Core functions Organization of public health services Health behavior Health promotion/disease prevention Environmental and personal health services Roles of public health practitioners/entities Organizing responses to public health crises Current and emerging issues
Community Assessment:	Biostatistics Data sources Collection and use of data Trend Analysis Gathering information from the community Matching programs to needs Cultural awareness Evaluation
Communication:	Public speaking Interviewing Grant writing Meeting facilitation Conflict resolution Marketing Understanding/using the media
Administration:	Public health management principles Personnel management Budgeting Strategic planning Program planning and prioritization Quality assurance/performance measures Evaluation/Cost-benefit analysis

Partnering:	Identifying your community Identifying potential partners and knowing when to approach them Mounting a community awareness campaign Maintaining ongoing groups/relationships Social Marketing
Leadership (dynamic):	Identifying issues of importance Visioneering Constituency development Working with elected officials and community leaders Working Collaboratively Balancing conflicting priorities Developing public policy
Billing/Record Keeping	Billing Fees Confidentiality issues Sharing of information Record keeping Data tracking
Why Public Health? (For affiliates/policy makers/others)	History of public health Health promotion/disease prevention Organization of services Community assessment Importance of public health today Current and emerging issues Partners Visioneering
Clinical/Technical Topics	As outlined in surveys and other data, but primarily updates and new-breaking issues